

5488

CERTIFICATE OF DEATH

05481

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Co. Hospital</u>				d. STREET ADDRESS <u>Owings, Md.</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>NELLIE Rebecca Armiger</u>				4. DATE OF DEATH Month Day Year <u>May 26 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 29, 1897</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Dunkirk, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph C. Brady</u>				14. MOTHER'S MAIDEN NAME <u>Annie V. Sears</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <u>Ellie W. Armiger, Owings, Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemiplegia</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Hypertension</u> DUE TO (c) <u>Diabetes</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>4 yrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac enlargement</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/26</u> , 19 <u>58</u> , to <u>5/26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/26</u> , 19 <u>58</u> , and that death occurred at <u>2:30</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H W Ward</u> M.D.				ADDRESS (Street, city or town, state) <u>Owings</u> DATE SIGNED <u>5/28/58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>5/29/58</u>		<u>Smithville Cemetery</u>		<u>Dunkirk Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm H. Hutchins</u> ADDRESS <u>Owings Md.</u>				24a. REC'D BY REGISTRAR <u>UN 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Hutchins</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH - DIVISION 14

<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Date of birth: _____</p>	
<p>4. Place of birth: _____</p>	
<p>5. Usual residence: _____</p>	
<p>6. Date of death: _____</p>	
<p>7. Cause of death: _____</p>	
<p>8. Signature of physician: _____</p>	
<p>9. Signature of registrar: _____</p>	
<p>10. Date of registration: _____</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE VITAL STATISTICS ACT, 1903, AND THE VITAL STATISTICS ACT, 1926, AND THE VITAL STATISTICS ACT, 1933, AND THE VITAL STATISTICS ACT, 1938, AND THE VITAL STATISTICS ACT, 1943, AND THE VITAL STATISTICS ACT, 1948, AND THE VITAL STATISTICS ACT, 1953, AND THE VITAL STATISTICS ACT, 1958, AND THE VITAL STATISTICS ACT, 1963, AND THE VITAL STATISTICS ACT, 1968, AND THE VITAL STATISTICS ACT, 1973, AND THE VITAL STATISTICS ACT, 1978, AND THE VITAL STATISTICS ACT, 1983, AND THE VITAL STATISTICS ACT, 1988, AND THE VITAL STATISTICS ACT, 1993, AND THE VITAL STATISTICS ACT, 1998, AND THE VITAL STATISTICS ACT, 2003, AND THE VITAL STATISTICS ACT, 2008, AND THE VITAL STATISTICS ACT, 2013, AND THE VITAL STATISTICS ACT, 2018, AND THE VITAL STATISTICS ACT, 2023.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9, Film G229, 5/26/58 fcy

CERTIFICATE OF DEATH

5489

05482

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		LENGTH OF STAY (In this place) <u>1 month</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u>		TOWN <u>088-2</u> ✓	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert Nursing Home,</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Ruth H. Austin</u>				4. DATE OF DEATH <u>May 18</u> 19 <u>58</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>		8. DATE OF BIRTH <u>Oct 8 1884</u>	
9. AGE last birthday <u>73</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Budgett</u>				14. MOTHER'S MAIDEN NAME <u>Ident.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Bernice Welch</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>4438</u> <u>Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive C.V. disease</u>				10 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cherity</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 15 1958</u> to <u>May 18</u> 19 <u>58</u> that I last saw the deceased alive on <u>May 15</u> 19 <u>58</u> and that death occurred at <u>5:15</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Ruth H. Austin</u>				ADDRESS (Street, city, town, state) <u>Prince Frederick</u>		DATE SIGNED <u>5/18/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/20/58</u>		NAME OF CEMETERY OR CREMATORY <u>Trinity</u>		LOCATION (City, town, or county) <u>Newport, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Ruth H. Austin</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt & Funeral Home</u>		ADDRESS <u>Waldorf, Md.</u>	
DATE <u>MAY 21 1958</u>							

CERTIFICATE OF DEATH

8120



NOTIFICATION

1. Name of deceased: John Doe
2. Sex: Male
3. Age: 45
4. Date of birth: Jan 1, 1900
5. Place of birth: New York City
6. Date of death: Dec 15, 1945
7. Place of death: Home
8. Cause of death: Heart Disease
9. Signature of physician: Dr. J. Smith
10. Signature of registrar: John Doe

1. Name of deceased	John Doe
2. Sex	Male
3. Age	45
4. Date of birth	Jan 1, 1900
5. Place of birth	New York City
6. Date of death	Dec 15, 1945
7. Place of death	Home
8. Cause of death	Heart Disease
9. Signature of physician	Dr. J. Smith
10. Signature of registrar	John Doe

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5490 **CERTIFICATE OF DEATH**

05483

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Porter, Pasadena</u>		<u>23</u>		TOWN <u>Cowrys</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Alice</u> (Middle) <u>Chase</u> (Last)				(Month) <u>May</u> (Day) <u>22</u> (Year) <u>1958</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Negro</u>	<u>widowed</u>	<u>Sept. 25 1895</u>	<u>82</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework</u>				<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James MacKall</u>				<u>Priscilla</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>Joanna Holland, Daughter</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>171X</u> IMMEDIATE CAUSE (A) <u>Cox of Cerebrum</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 22, 1958</u>, to <u>May 22, 1958</u>, that I last saw the deceased alive on <u>May 22, 1958</u>, and that death occurred at <u>8:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>[Signature]</u>				<u>M.D. Huntington</u>			
DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>1</u>		<u>4-26-58</u>		<u>Potomac</u>		<u>Huntingtown Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>[Signature]</u>		<u>[Signature]</u>		<u>P.S. Sewell P.O. Fred, Md</u>			
DATE <u>MAY 29 1958</u>							

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DECEASED

DATE OF BIRTH

PLACE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Marital Status

Usual Residence

Present Residence

Place of Death

Time of Death

Cause of Death

Manner of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Nurse

Signature of Chaplain

Signature of Minister

Signature of Priest

Signature of Rabbi

Signature of Imam

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

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Signature of Other

Signature of Other

MISSISSIPPI

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5491 CERTIFICATE OF DEATH

05484

Item 9, Film G229, 5/16/58 fcy

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		STATE <u>Md.</u>		COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Prince Frederick</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Huntingtown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Jacob Coby</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 6 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10/27/91</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Coby</u>				14. MOTHER'S MAIDEN NAME <u>Maria Coby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Henrietta Coby, Huntingtown, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
026X IMMEDIATE CAUSE (A) <u>Arteriosclerosis Cardio Vascular Panel</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>7 Luetia (Meninge Vascular fues)</u>				<u>25 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 20, 1958</u> to <u>May 6, 1958</u> , that I last saw the deceased alive on <u>May 5, 1958</u> , and that death occurred at <u>8:20</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>Prince Frederick</u>		ADDRESS (Street, city, town, state) <u>Calvert, Co. Md</u>		DATE SIGNED <u>5/6/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>5-9-58</u>		DATE THEREOF <u>5-9-58</u>		NAME OF CEMETERY OR CREMATORY <u>Blue Point</u>		LOCATION (City, town, or county) (State) <u>Calvert, Co. Md</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. I. Sewell</u>		ADDRESS <u>Prince Fred, Md.</u>	
DATE <u>MAY 12 58</u>							

CERTIFICATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
This certificate is to be filled out by the attending physician or the coroner, and is to be filed in the office of the Registrar of Vital Statistics, Boston, and in the office of the Registrar of Vital Statistics, in the town or city where the death occurred.
The certificate is to be filled out in duplicate, and the original is to be filed in the office of the Registrar of Vital Statistics, Boston, and the duplicate is to be filed in the office of the Registrar of Vital Statistics, in the town or city where the death occurred.
The certificate is to be filled out in duplicate, and the original is to be filed in the office of the Registrar of Vital Statistics, Boston, and the duplicate is to be filed in the office of the Registrar of Vital Statistics, in the town or city where the death occurred.

5492

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Huntingtown Rest Home</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Taney</u> Middle <u>Weems</u> Last <u>Gibson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7, 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Calvert County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Gibson</u>		14. MOTHER'S MAIDEN NAME <u>Cornelia Weems</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. George D. Clark</u> Address <u>713 Mynduck Rd., Baltimore</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO <u>-</u> (c) <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2 Feb. 1957</u> to <u>29 May 1958</u> , that I last saw the deceased alive on <u>29 May 1958</u> , and that death occurred at <u>3:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. J. Weems</u>		ADDRESS (Street, city or town, state) <u>Huntingtown Md</u> DATE SIGNED <u>31 May 58</u>	
PHYSICIAN'S NAME (Type) <u>G. J. WEEMS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 31, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cal Saints</u>	22d. LOCATION (City, town, or county) (State) <u>Sunderland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Harkness & Son</u> ADDRESS <u>Mt. Airy, Md.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		DATE <u>JUN 3 1958</u>	<u>W. L. Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2103

NEW YORK

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, place of death, cause of death, and signatures of witnesses and the official.

NAME: *John Doe*

AGE: *45* SEX: *M* RACE: *W*

DATE OF DEATH: *Jan 15 1920* PLACE OF DEATH: *Home*

CAUSE OF DEATH: *Heart Disease*

SIGNATURES: *John Doe* (Official), *John Doe* (Witness), *John Doe* (Witness)

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
See Birth Certificate - fcy

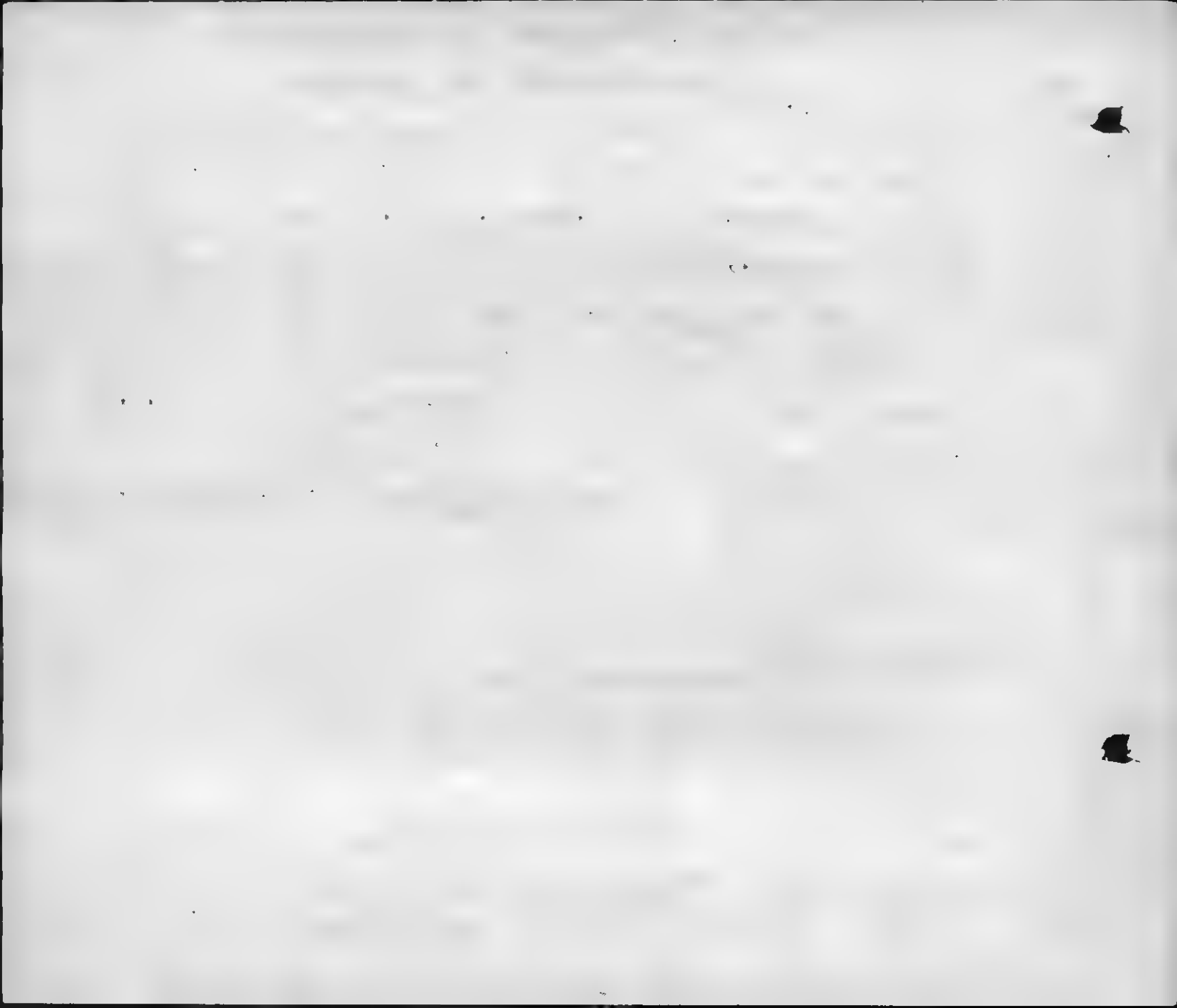
CERTIFICATE OF DEATH

5493

05486

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Prince Frederick</u>		<u>12Hr.40 Min.</u>		TOWN <u>St. Leonards</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert Co., Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Leonard Darrynell Harrod</u>				<u>5</u> <u>II</u> <u>1958</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH		9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.
<u>Male</u>	<u>Negro</u>		<u>April 2 1958</u>		<u>5 Weeks</u>	<u>5</u> Days	<u>Hours</u> <u>Min.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					<u>Maryland</u>		<u>U.S.A</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George Harrod</u>				<u>Sherba Steward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mother Sherba Steward St. Leonard</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Malnutrition</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO							
DUE TO							
DUE TO							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/11/58</u>, 19<u>58</u>, to <u>5/10</u>, 19<u>58</u>, that I last saw the deceased alive on <u>5/11</u>, 19<u>58</u>, and that death occurred at <u>5/10</u>, M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>[Signature]</u>		DATE SIGNED <u>5/14/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-13-58</u>		<u>Brooks</u>		<u>Island Creek md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>[Signature]</u>		<u>P. E. Sewell</u>		<u>Prince Fred.</u>	
DATE <u>MAY 16 58</u>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05487

Reg. Dist. No.

1. PLACE OF BIRTH a. COUNTY <i>Cabot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Cabot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edelma</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>William A Hooper</i> First Middle Last Sr		4. DATE OF DEATH Month <i>5</i> Day <i>25</i> Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/30/77</i>
9. AGE (In years last birthday) <i>80</i> yrs.		10. IF UNDER 1 YEAR Months <i>11</i> Days <i>25</i> Hours <i></i> Min. <i></i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Cycleman</i>	
13. FATHER'S NAME <i>Elmer Hooper</i>		14. MOTHER'S MAIDEN NAME <i>Mary Buck</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-14-3089</i>	
17. INFORMANT <i>Wm A Hooper Jr</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular renal disease</i> <i>1971</i> DUE TO (b) <i>Age, Coronary embolism</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>Cancer of stomach</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Walk into a power room, sat in chair and</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DISSEMINATED INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Stroke in 3 min</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> o. m. <i></i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H W Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. W. WARD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 28, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Central Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Cabot County, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Zarkness & Son - Mutual, Inc</i>		24a. REC'D BY REGISTRAR <i>May 28 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. H. Smith</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

5495

05488

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cabaret</u>		MARYLAND		STATE <u>Ind</u>		COUNTY <u>Cabaret</u>	
CITY OR TOWN <u>Prince Frederick</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Huntingtown</u>		(If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cabaret County Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Edward P. Miller</u>				4. DATE OF DEATH <u>May 14, 1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>		8. DATE OF BIRTH <u>Feb. 2, 1878</u>	
9. AGE last birthday <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Thomas J. Miller</u>			
14. MOTHER'S MAIDEN NAME <u>Alpha Ray</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>217-36-7372</u>				17. INFORMANT & ADDRESS <u>Mr. Jessie Miller, Huntingtown, Ind.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
442x IMMEDIATE CAUSE (A) <u>hypertensive C.V.R. disease</u>							
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2110</u> , 19 <u>45</u> , to <u>14 May</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>14 May</u> , 19 <u>58</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>M.D. Huntingtown Ind.</u>		DATE SIGNED <u>5/19/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 17, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Miranda Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cabaret Co., Ind.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Farkness & Son - Mutual, Ind.</u>		ADDRESS	
DATE <u>MAY 20 '58</u>							



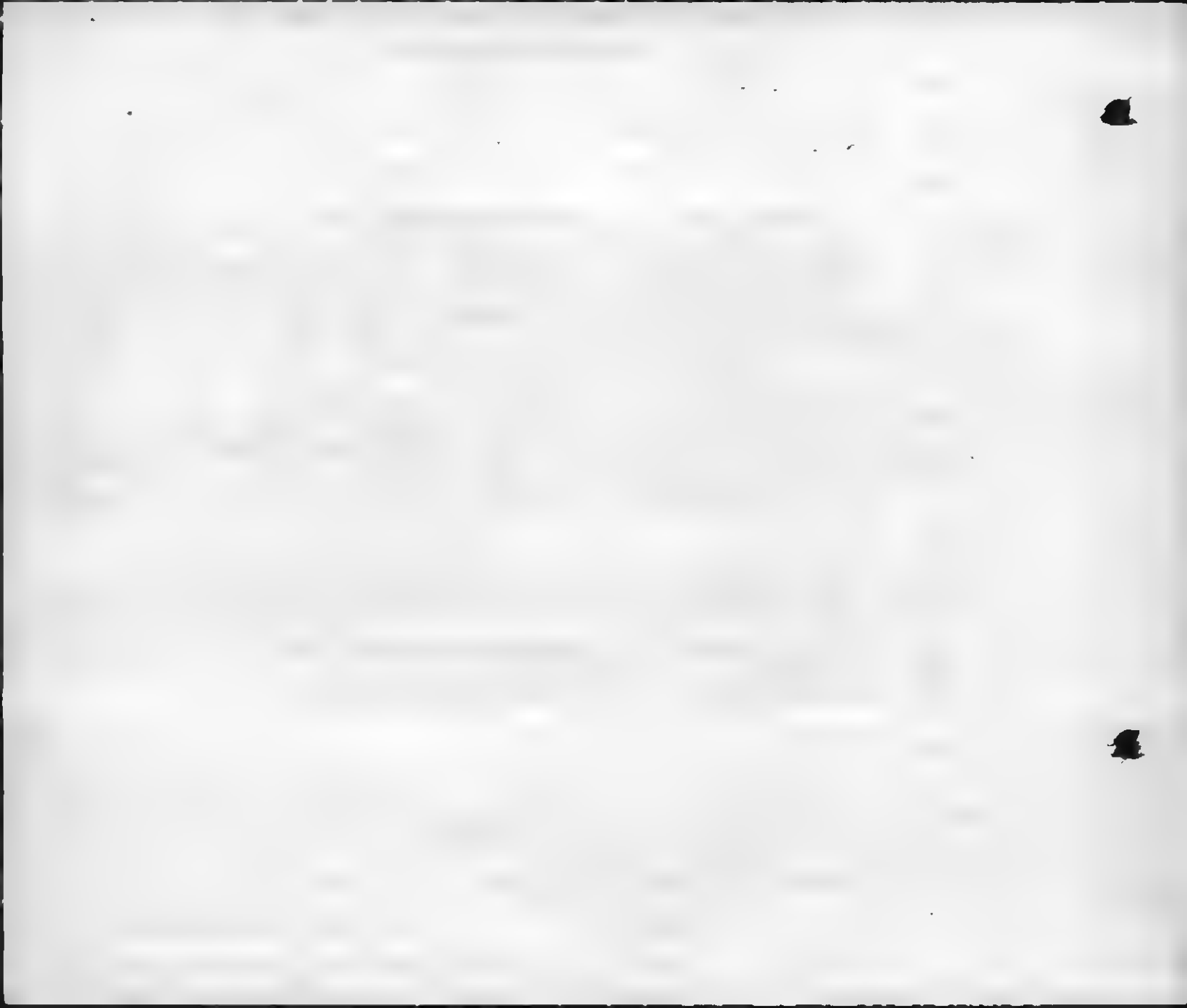
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5496 CERTIFICATE OF DEATH

Reg. Dist. No. 05489

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barstow</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barstow</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles A. Moore</u>		4. DATE OF DEATH Month Day Year <u>May 27, 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 28, 1882</u>
9. AGE (In years lost birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Calvert Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Moore</u>		14. MOTHER'S MAIDEN NAME <u>Annie Fowler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-34-4841</u>	
17. INFORMANT <u>Lilbie E. Moore - Barstow, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 27</u> , 19 <u>58</u> , to _____, 19____, that I last saw the deceased alive on <u>1958</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert Jett</u>		M.D. <u>James Frederick</u> <u>MD/28/58</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT C. JETT</u>		ADDRESS (Street, city or town, state) <u>PRINCE FREDERICK MD</u>	
DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 30, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>O.A. Harkless & Son - Mutual, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 2 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			



FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2'57

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 05490										
1. PLACE OF DEATH a COUNTY Calvert MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a STATE Va. b COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trevillian			d. STREET ADDRESS Trevillian Va.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital					e. IS RESIDENT ON A FARM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MEREDITH EMMETT RAGLAND					4. DATE OF DEATH May 17, 1958					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 10, 1896		9. AGE (in years last birthday) 61 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Sawmill			11. BIRTHPLACE (State or foreign country) Pondexter Va.			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Nathaniel Ragland					14. MOTHER'S MAIDEN NAME Nannie James					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO		17. INFORMANT J.F. Bell 108 6th St. Charlottesville Va.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Dislocation of 4th Cervical Vertebra 903.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) 903.5 DUE TO c) 903.5										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 903.5										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fall to ground, hitting head on a tree							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5/17/58			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Huntingtown (County) Calvert (State) Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE William V. Lovitt, Jr.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 5-18-58				
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Shipped			22b. DATE THEREOF May 20, 1958		22c. NAME OF CEMETERY OR CREMATORY Springfield		22d. LOCATION (City, town, or county) Springfield (State) Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Katie R. Williams					ADDRESS 322 N.		24a. REC'D BY REGISTRAR DATE MAY 20 '58		24b. REGISTRAR'S SIGNATURE W. L. Smith	

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CERTIFICATE OF DEATH

05491

Reg. Dist. No.

5498

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		LENGTH OF STAY (in this place) <u>New born</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Girl</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 25</u> 19 <u>58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>May 25, 1958</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Betty Dalrymple</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Betty Robinson - Huntingtown, md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>MALFORMATION with</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hydramnios</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/25</u> , 19 <u>58</u> , to <u>5/25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/25</u> , 19 <u>58</u> , and that death occurred at <u>11:05</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Robert Robinson</u>				ADDRESS (Street, city, town, state) <u>St Leonard</u>			
DATE SIGNED <u>5/25/58</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 25, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Private</u>		LOCATION (City, town, or county) (State) <u>Huntingtown, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>MAY 28 '58</u>		REGISTRAR'S SIGNATURE <u>Robert Robinson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Robinson</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M-1

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5499

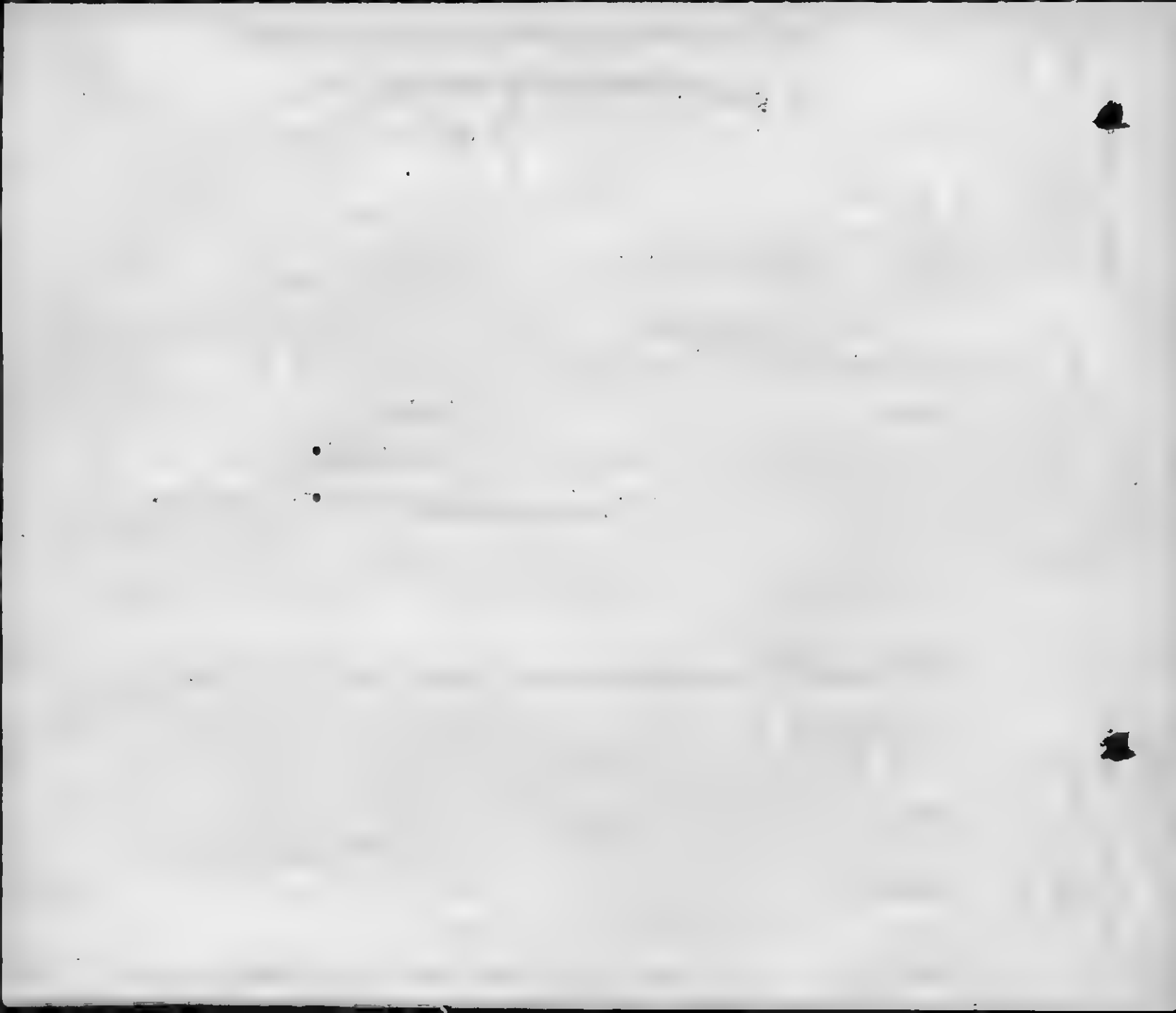
CERTIFICATE OF DEATH

Item 9 Film 3229 6-5-58 et

05492

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Calvert</u>	
CITY OR TOWN <u>Prince Frederick</u> (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Olivet</u> (If outside corporate limits, write RURAL and give nearest town)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>				STREET ADDRESS <u>1</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Leroy</u> (First) (Middle) (Last) <u>SUTTON</u>				4. DATE OF DEATH May 20 19 58 (Month) (Day) (Year)			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>May 19, 1904</u>	9. AGE last birthday <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Mins.		IF UNDER 24 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Cole</u>				14. MOTHER'S MAIDEN NAME <u>Lucinda Sutton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-14-5973</u>		17. INFORMANT & ADDRESS <u>Lucinda Sutton, Olivet, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5/12/58</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic C.P. Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> al work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/13</u> , 19 <u>58</u> , to <u>5/20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/20</u> , 19 <u>58</u> , and that death occurred at <u>10:45</u> M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>[Signature]</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>5/20/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>4-25-58</u>		NAME OF CEMETERY OR CREMATORY <u>Eastern Chapel</u>		LOCATION (City, town, or county) (State) <u>Calvert Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. J. Sewell</u>		ADDRESS <u>Pr. Fred. Md</u>	
DATE <u>MAY 20 1958</u>							



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INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

1 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5560 **CERTIFICATE OF DEATH**

Reg. Dist. No. 05493

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>St. Marys</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Prince Frederick</u>		LENGTH OF STAY (in this place) <u>11 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Benedict</u>		<u>08X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert Co. Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>haine</u> (First) <u>Washington</u> (Last)				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>26</u> (Year) <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1905</u>	9. AGE last birthday <u>53</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Robert Washington Hubert Benedict Ad</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Le Roy Washington, Benedict</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
570.5 IMMEDIATE CAUSE (A) <u>TOXEMIA - UREMIA</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO				<u>Possible intestinal obstruction (?)</u>			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/> 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>5/16</u> , 19 <u>58</u> , to <u>5/26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/26</u> , 19 <u>58</u> , and that death occurred at <u>12</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Rowellanese</u> M.D.				DATE SIGNED <u>5/26/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/29/58</u>		NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		LOCATION (City, town, or county) (State) <u>Bryantown Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Cherish</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>			
DATE <u>JUN 2 '58</u>							

...and the ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5501 CERTIFICATE OF DEATH

05494

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Haydon</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Co. Hospital</u>		d. STREET ADDRESS <u>Dunkirk, Md</u>	
3. NAME OF DECEASED (Type or print) First <u>PEGGY</u> Middle <u>LEE</u> Last <u>WATKINS</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 21, 57</u>
9. AGE (In years last birthday) <u>7 months</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Watkins</u>		14. MOTHER'S MAIDEN NAME <u>MATTIE RANDALL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>FATHER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> DUE TO <u>Robert pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 days</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 6, 1958</u> to <u>May 17, 1958</u> , that I last saw the deceased alive on <u>May 11, 1958</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. de Villareal</u> M.D.		ADDRESS (Street, city or town, state) <u>St. Howard</u> DATE SIGNED <u>5/12/58</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT G. DE VILLAREAL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>513, 58</u>	22b. DATE THEREOF <u>Coopers</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dunkirk, Md</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u> ADDRESS <u>Prince Fred, Md</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 16 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur</u>

2064338XVL

CERTIFICATE OF DEATH

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Form with multiple horizontal lines for text entry, including fields for name, date, and cause of death.

Vertical text on the right margin, likely containing administrative or filing information.